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RESILIENCE AS A CHANCE OF DEVELOPMENTAL SUCCESS FOR A CHILD WITH A CHRONIC ILLNESS

Abstract

Chronic physical illness considered as a negative event, a potential stressor or a life crisis can be the risk factor for difficulties in the development of a child. Negative consequences of transactional influence of the factors associated with illness parameters, a child's personality and his or her environment occur particularly in the emotional and social development. This situation can be also the chance for stimulating a development of a child's personality and his or her growing as a person. The theoretical construct that in right way explains the positive transformation in understanding of the context of chronic illness – is a resilience. The meaning of this construct is discussed from the perspective of model proposed by E. Groetberg and assumptions of positive psychology, while its application value is showed in the light of the empirical data. The conceptualization of a developmental success refers to psychological well-being and being a mature and optimally functioning person.

Key words: child with a chronic illness, resilience, developmental success, psychological well-being, mature and optimally functioning person

Chronic somatic diseases are a civilizational hallmark of the life of contemporary man at all stages of his development. Medical statistics of the last a few decade shave shown an increase in the incidence of some chronic conditions, e.g. diabetes type I, allergy, asthma, or cancers. It is assumed that about 31% of children and youth under 18 suffer from different somatic diseases more often characterized by a mild course (66%) than a moderate (29%) or severe one (5%), significantly limiting their everyday life activity (Newacheck, Taylor, 1992).

The contemporary understanding of a chronic somatic disease is based on the biopsychological model of health and disease perceiving disease as

a potential stressor that transforms the life of the child and his or her family, entailing certain demands and limitations that the child and the family have to face up to. The process of coping with a new, difficult situation is called adaptation. It does not consist in passively adjusting to new requirements through behavior modifications but in a creative response to encountered difficulties and dangers, supposedly resulting in the end in a positive cost-benefit analysis. Somatic problems in children and youth are always connected with their social and emotional functioning that is either a cause or effect of such problems (Thompson, Gustafson, 1996; Pilecka 2002).

Contemporary research provides evidence that most children with chronic illnesses function as well as their healthy peers or in some cases even better (Barakat, Pulgaron, Daniel, 2009). R.B. Noll and M.J. Kapust (2007) believe that the so called *hardiness* is a theoretic construct that effectively explains why and in what way children diagnosed to suffer from cancer reach a successful level of psychosocial adaptation. At present, however, pediatric psychological literature far more often refers to the term *resilience* whose definitions strongly highlight factors constituting direct indicators of an effective adaptation to stressful circumstances.

How to understand resilience

psychological literature provides many definitions of resilience, all of them provoking critical discussions, highlighting the complexity and ambiguity of the term. Yet, as popularly understood, the concept seems easy to define. In the evolution of views on the essence of children's resilience, M. O'Dougherty-Wright and A. Masten (2006) distinguish three waves:

- wave I: identifying individual resilience and its determinants;
- wave II: embedding resilience in developmental and ecological systems, with a focus on its processes;
- wave III: fostering resilience through preventive interventions modifying the child's development.

At the time of the first wave, i.e. the latter half of the 70s and the first half of the 80s, researchers tried to accurately describe resilience, taking into account its different characteristics. Most often it was discussed with regard to positive adaptation to past and present adversities, with an assumption that resilience is responsible either for a general or unique level of this adaptation. As O'Dougherty-Wright and Masten state, researchers attempted to describe the criteria for resilience, and its internal and external determinants. Resilience was defined in the first place in terms of assets, compensatory or promoting factors enabling the child to achieve effective adaptation in all difficult situations, even those related to a highest risk. Resilience was attributed with particular

significance by some authors; they perceived it as a protective factor manifesting itself exclusively in high-risk situations. The determinants were usually divided into four groups:

- characteristics of the child: temperament qualities, good level of intellectual development, effective coping strategies, positive self-perception (self-confidence, high self-esteem, sense of self-effectiveness), positive attitude to life (attitude of hope), sense of meaning in life, traits important from the perspective of society (talents, sense of humor, attractiveness to others);
- characteristics of the family: stable and supporting home (rare conflicts, emotional closeness, parents' authority, positive relationships between siblings, support from more distant relatives), supporting the child in education, socioeconomic status, level of parent's education, religious beliefs;
- characteristics of the environment: good neighborly relations, education services, employment chances for parents and relatives, good healthcare, public safety services, significant persons and socially-minded peers;
- characteristics of the culture and social policy: legal protection of children, values promoted in education, prevention of and protection from political violence, low tolerance for physical violence.

During the second wave, particularly in the 90s, researchers endeavored to understand the processes leading to acquiring resilience in the course of human development. With that in mind, they drew on the achievements of biology, sociology and humanities in order to show relations the individual has with other systems at various levels of their organization during the whole life, and mechanisms that the individual uses to develop his or her own complex of adaptive mechanisms. The child's relations with his or her ecosystem context became a subject of the empirical studies of the time. The child's perception and interpretation of his or her experiences was acknowledged as a factor considerably modifying these relations. The significance that the child ascribes to these experiences determines the effect the context has on his or her adaptation and resilience. The very resilience was also described then as a dynamic and multidimensional process determined by transactional relations between individual and contextual factors. At that time, studies provided evidence that the same child can be diagnosed as resilient at a certain time of his or her life and not resilient at another one, that the child can show resilience in certain situations, and not in other ones; and finally, that the child can be resilient only to certain events in his or her life.

The third wave – the last decades – is characterized by an intense search for intentional ways of fostering resilience in children from risk groups and in children whose development is not disturbed. Basing on various theoretical assumptions, researchers started to construct programs intended to reinforce both individual and environmental assets of the child, and to reduce risk factors. Those

programs are built with an intention to modify the behavior of parents, teachers, professionals, as well as children themselves. The programs can be of promoting or preventive, and of corrective, i.e. remedial, character.

Summing up the presented discussion it can be stated that in the subject literature resilience is most often defined descriptively at a varying level of generality. *Resilience is predominantly defined as children's ability, quality or competence to carry out their developmental tasks effectively or to achieve positive adaptation despite chronic problems, often severe ones, that they can face in the course of their life.*

The definition worked out by E. Grotberg (2000, p. 14), that is a definition of a high level of generality, says that resilience is a universal capacity which allows a person, group or community to prevent, minimize or overcome the damaging effects of adversity.

P. Wyman, I. Sandler, S. Wolchik and K. Nelson (2000, p. 133) believe on the other hand that resilience is a competence enabling the child to achieve positive developmental goals and avoid non-adaptive behaviors, particularly in crisis situations.

Another general definition is also the one proposed by M. Tyszkowa (1986). According to her resilience is an ability of an individual to oppose frustrating and stressing effects of a difficult situation by staying at a proper level of cognitive understanding of the situation and emotional control based on this understanding (p. 337).

Narrow-range definitions show resilience as a capacity to achieve positive goals by children from risk groups, i.e. those exposed to violence, poverty, permanent limitations or health-related risks, etc., a competence making it possible to effectively cope with stress or an ability to constructively struggle with trauma. In these definitions, resilience is perceived as one of personality dimensions, along with self-evaluation, locus of control, hardiness or temperament (quoted after: Jordan, 2006).

The role of resilience in the psychosocial development and functioning of children with chronic somatic diseases can be better understood in view of E. Grotberg's model and the theoretical assumptions of positive psychology.

Resilience according to Edith Grotberg

Among the factors highly determining resilience in childhood and adolescence are cognitive processes understood both as general intelligence as well as processing and organizing information about oneself in certain mental structures. General cognitive abilities constitute a strong and constant predicator of resilience. Children able to effectively solve cognitive problems will certainly manage well in difficult situations as they will have a richer and more diverse range

of remedial strategies at hand. Apart from intelligence also abilities and skills of social cognition, i.e. factors responsible for the integration and safety of the I and for a sense of control, play here an important role. The most important cognitive patterns include: (1) the perception and evaluation of social support, (2) self-esteem, and (3) self-efficacy. The first pattern refers to the child's faith and trust in people around: the child believes that he or she is loved and can always count on being helped in difficult situations. The second oneis shaped on the basis of other people's opinions. The third pattern refers to the conviction that the set goals can be reached in spite of potential obstacles. High self-esteem and self-efficacy successfully protect the child against the negative effects of various risk factors.

E. Grotberg (2000) writes that there are three sources of resilience of the child: **I have**, **I am**, and **I can**. Factors within category **I have** include internal sources of support; according to the author, these are:

- interpersonal relationships based on trust: children at any age need both the unconditional love from their parents and caregivers, and positive emotions from other adults that can sometimes compensate the former ones;
- clear house rules: house rules and routines set tasks for the child who is rewarded for performing them, and, consequently, should accept them more easily; when the child does not follow the accepted rules, he or she is helped to understand his or her behavior and encouraged to express his or her point of view; punishment is used as a last resort;
- social role models: the child learns to do a variety of things properly; adults play a role of his or her moral models and pass on religious beliefs;
- encouragement to autonomy: adults, particularly parents, encourage the child to become independent, to search for help in difficult situations; they praise the child for autonomy and initiative;
- access to healthcare, education, welfare and public safety institutions: these services address those needs of the child that parents are not able to address;

Factors contained in category **I am** include the child's personal traits described as follows:

- loveable, attracting other people's attention: the child is aware that other people like and love him or her; the child wants to deserve this love by taking actions that are worth attention; the child maintains a proper balance between animation and calmness;
- loving, empathic, altruistic: the child loves other people and shows it in many ways, empathizes with and relieves other people's suffering and pain;
- proud of oneself: the child has a sense of importance and self-acknowledgement because he or she knows his or her strong and weak points; the child does not let other people belittle him or her; the child's self-trust and self-esteem let him or her manage successfully in difficult situations;

- independent and responsible: the child is capable of taking different actions and their consequences; the child has a sense of agency and accepts responsibility, acknowledges other people's control and responsibility;
- full of hope, faith and trust: the child believes that other people trust him or her but also that he or she trusts them; the child has a sense of good and evil, wants to multiply good, turns towards higher values;

Factors belonging to category **I can** include the child's social and interpersonal skills, aptly expressed by the following verbs:

- communicate: the child is able to communicate his or her thoughts and emotions towards others; the child can accurately interpret and understand other people's emotions, and responds to them;
- solve problems: the child can determine the core of the problem and plan its solution, negotiate solution options; the child can find creative solutions, with a certain measure of self-irony;
- cope with his or her own feelings and impulsiveness: the child is able to recognize and name his or her emotions and feelings, refrain from impulsive behaviors and those causing other people's pain;
- assess his or her own and other people's temperament: the awareness of his or her own traits and responses helps the child to behave adequately in many situations;
- establish interpersonal relationships based on trust: when in danger, the child is able to find somebody whom he or she would ask for help with solving internal or external conflicts.

A resilient child does not have to manifest all of the above-mentioned qualities, yet surely their broader range and higher level of intensity would guarantee a higher-quality psychological resilience. As Grotberg's studies show, only 38% of parents consciously foster resilience in their children; other children become resilient at high psychosocial costs.

Resilience of children with chronic conditions from the standpoint of positive psychology

Positive psychology is a relatively new current, both in the theory and practice of psychology – it was initiated in 1998 by M. Seligman, M. Csikszetmihalyi and R. Fowler. The founders of this sub-discipline modified the focus of psychology – its excessive concentration on deficits – to take a closer look also at assets in the functioning of man, in other words, they proposed a shift in the focus of psychological studies from the weakest points in the life of man to what makes it worth living. The overriding aim of positive psychology as a branch of knowledge and practice is then striving after a better and better understanding of not only abnormalities that may occur in human behavior, and man's

negative responses to trauma but also, and perhaps more than anything else, of the process of man's adaptation to different life situations, of positive emotions, adaptive coping ways and hope (Gable, Haidt, 2005; Linley, Joseph, Harrington, Wood, 2006).

The ideas of positive psychology have quickly spread to the health psychology, rehabilitation psychology and clinical psychology, reinforcing their theoretical basis and outlining the new directions of studies. It turned out that the achievements of the new trend are intensely related to the theoretical and empirical findings of the above-mentioned sciences with regard to children. These relations have become clearly visible in the study of resilience – with post-traumatic growth and health-related quality of life of children and youth most often recognized as its indicators – and in the study of factors securing the development and functioning of children and youth in the case of external (e.g. poverty, violence, cataclysm) and internal (e.g. disability, severe somatic disease) dangers.

Post-traumatic growth refers to positive changes in the functioning of man resulting from experiencing traumatic events. Such changes usually include: discerning new opportunities in life, higher appreciation for life, improved social relations, an increased sense of one's personal power, and spiritual development. In the terminology used to describe those changes there are such expressions as: discovering meaning, flourishing, drawing strength from adversity or transformative coping (quoted after: Ogińska-Bulik, Juczyński, 2008). A study of post-traumatic growth in children and youth is rarely undertaken, most often because of methodological problems. L.P. Barakat, M.A. Alderfer and A.E. Kazak (2006) discovered that as many as 85% of teenagers suffering from cancer pointed out at least one positive change in themselves resulting from experiencing a difficult situation, and one-third of them could see four or more such changes. S. Phipps (2007), on the other hand, stresses a positive correlation of post-traumatic growth with optimism and self-evaluation, and its negative correlation with fear in tested groups of children with an oncological disease. According to M. Stępa (2006), one-third of youth suffering from asthma, diabetes or moderate and severe physical disability perceive a sense of their life situation in positive terms. Physically disabled youth is a group most often positively perceiving their health problem (48.33%), then there are youngsters suffering from asthma (35%), and finally diabetes (23.33%). Limitations and requirements resulting from health problems constitute a challenge for subjects; for some it is a chance to carry out new tasks, goals and values, for others – a specific kind of experience. The meaning ascribed to one's own disease, more than the knowledge of it or the concomitant emotions, determines the examined youth's adaptive difficulties. A negative meaning occurs together with externalizing difficulties, and particularly with a tendency towards problematic behaviors with predominant aggression. Youth discovering a meaning in their struggle with limitations and requirements that their disease entails, much more seldom manifest abnormalities in their social functioning. In

recent years new studies have appeared (Zebrack, Chesler, 2002), showing a positive effect of a situation of cancer disease on the psychosocial development of youth. Young people undertake a reconstruction of their life goals, reinforce their resilience, build a positive attitude towards life, the attitude dominated by the acceptance of what life brings and tolerance towards other people. L.P. Barakat, E.R. Pulgaron, L.C. Daniel (2009), on the other hand, refer to various researchers whose findings show that children in cancer remission evaluate their life quality higher than their healthy peers, while children suffering from asthma, diabetes and cystic fibrosis ascribe a lower quality to their life.

According to L.P. Barakat, E.R. Pulgaron and L.C. Daniel (2009), among the factors protecting and reinforcing resilience in children and youth with chronic conditions are: self-esteem, hope and optimism, active coping, repressive adaptive style, family functioning and social support.

Self-esteem, in the opinion of A. Jakubik (1997), is a belief in an autonomous value of oneself and an expectation of its confirmation by other people and oneself. According to H. Grzegołowska-Klarkowska (1989), self-esteem constitutes a global feeling, a subjectively experienced global assessment of oneself. The development of self-esteem is related to two factors: self-evaluation in the areas important to the individual and an assessment of perceived relations with significant persons (Harter, 2005). The global self-esteem of children and youth with chronic illnesses does not differ significantly from that of their healthy peers. Lowering or inflating tendencies with regard to self-evaluation occur when young people face failures and negative emotions from other people (rejection and stigmatization). Moderately raised self-esteem enhances the realization of life goals and acquisition of social competences; it protects the person from fear, depression and asocial behaviors (e.g. avoiding, opposing, rebelling, egocentric behaviors). Positive self-esteem is recognized as the most important factor in the optimal functioning of the individual (Harter, 2005; Barakat, Pulgaron, Daniel, 2009).

Having hope is a fundamental condition of being a human. The losing or shattering of hope leads to the destruction of life. According to E. Fromm (2000), hope represents man's internal state that determines readiness for an intensive, though still unfulfilled, activity that would enable the person to achieve the fullness of life. It is such an internal state that makes the person follow "the inner voice," namely act, change oneself and the world always "for the better." Our life and the life of other people changes all the time, it is never the same, thus we also do change, we can overcome our weaknesses and limitations or give in to them. At every second of our life we can be stronger or weaker, wiser or dumber, bolder or more cowardly. Losing hope gives way to the indifference of the heart, hatred towards the world, desire to destroy it. V.E. Frankl (2009) by contrast believes that hope is a manifestation of the internal attitude of the individual and his or her will positively oriented towards life in general. It motivates man to accept what life brings, makes it possible to fight off the feeling of resignation

or escape from life. Hope facilitates changes in the way we perceive our life situation, helps us to acquire the ability to interpret the world optimistically and to constantly improve the quality of our life. It is worth here to supplement Frankl's thoughts with M. Seligman's deliberations on optimism (1993). According to him, optimism helps man in four ways: it prevents a sense of helplessness and impotence, enhances our activeness when we have problems, and our aspiration to overcome them; it facilitates deep emotional relations with other people, protects us from too many adversities. The sources of optimism lie in the person's resourcefulness, positive attitude to life and the world, as well as in a style of explanation. The studies of hope and optimism in children and youth suffering from diseases that may lead to death or disability have shown that a higher level of hope and optimism is a predicator of effective adaptation to the limitations and discipline that the treatment and rehabilitation entail, of coping with pain and of higher expectations with regard to the process of education (Barakat, Pulgaron, Daniel, 2009).

Active coping includes effective ways of problem solving and a skillful search for and use of social support. The results of using such strategies depend on how they fit to the character of the problem, on the cognitive abilities and personality traits of children and youth, as well as on the duration of coping – avoidance strategies are most effective at short intervals of time, while problem-centered strategies – at longer ones. Emotional support plays an important role in active coping. Active coping enhances social adaptation, lowers the level of fear, reinforces self-esteem, relieves pain (Barakat, Pulgaron, Daniel, 2009; Pilecka, Fryt, 2011).

The essence of a repressive adaptive style lies in a low level of fear and a strong tendency to use defensive reactions and behaviors (avoidance, denial, withdrawal). This type of adaptation occurs in situations in which hardly controllable and non-modifiable stressors operate – e.g. in danger of disability or death. S. Phipps with a group of researchers (2006) pointed out that children suffering from cancer manifested a higher level of repressive adaptive style than healthy children. This dimension of functioning of children and youth with health and developmental problems has been poorly examined in empirical studies.

Family functioning is one of the most crucial determinants of the psychosocial development of every child. The subject literature highlights the importance of two dimensions: cohesion and adaptability, whose levels reveal the character of relations in the family and of the family with more distant circles of community. Cohesion refers to the emotional closeness of family members and at the same time their sense of autonomy within the family as a system. The relationship between this dimension of functioning and resilience of children is most often explored in the studies of active and affective family involvement and the specificity of interactions between parents and children. Adaptability of the family refers to its ability to modify its goals, principles, roles and leadership in order to maintain or reconstruct the inner balance in confrontation with

serious dangers. Fostering resilience in children is particularly determined by two components of family adaptability: parental conduct also called a parenting style, and the modes of problem solving in view of the system of beliefs and values. Affective involvement refers to the degree to which family members value and manifest their interest in the actions of other family members. The intensity of this interest and the ways in which it is manifested are stressed. The development of resilience and healthy adaptation of children are related to the empathic involvement of other family members. An active involvement of family members in children's actions makes it possible to shape children's positive attitudes towards school, prevent their absence from school, help them achieve high marks and eliminate problematic behaviors. A shared system of values, beliefs and expectations, in the subject literature called a family schema, family world view or family cohesion, constitutes a significant indicator of family adaptability (quoted after: Sheridan, Eagle, Dowd, 2006). The family with a strong family schema looks at life realistically and does not expect prefect solutions for difficult situations. In its actions, such a family is more WE- than I-oriented. The members of a resilient family judge critical moments in the life of the family similarly, solve financial problems together, and organize their time together. They provide a lot of support to each other. Strong family resilience is a source of its each member's individual resilience. The very family itself, however, does need a formal and informal support of the external community with fostering its resilience through reinforcing the competences, strength and skills of its members and the whole family as a system.

The scope of the term *social support* is extremely broad and it includes diverse forms of help: sympathy, raising hope and encouragement, practical help, providing information, etc. A range of help and a number of people providing support are perceived as objective indicators of social support. In comparative studies of a network of social support for families with chronically sick and healthy children, no quantitative nor qualitative differences were found with regard to the size of the network, yet the studies proved its positive impact on the psychosocial adaptation of the child and his or her family. The network cannot be too dense (many persons providing support through mutual communication and action), as in such a case the activeness of its members disturbs the functioning of the family as a system. The activeness intensifies the system's cohesion to such a degree that it becomes a factor that curbs the independence and autonomy of family members and hinders expressing negative emotions by family members, especially their discontent with and a kind of disapproval of some aspects of family life. People providing informal support (more distant relatives, old and new friends) usually trigger sources of formal support, i.e. institutions launched to provide this kind of support, e.g. health and/or rehabilitation centers, associations.

Formal support refers to help that parents can get from institutions and professionals. In general parents expect reliable and understandable information on the disease or developmental problems of their child, as well as practical tips for nursing, care, up-bringing and rehabilitation. Parents differ in terms of their ability to understand and assimilate the information they are given, to formulate questions, as well as with regard to the modes of expressing their concerns and worries. Professionals should not only see to it that they inform parents in the way adequate to the parents' level of education and ability to understand the information they are given, but they should also ask extra questions to estimate the parents' needs with regard to the treatment, rehabilitation, care and up-bringing of the child.

Informal support comes from the family, friends, neighbors, as well as from organizations, associations whose members provide help voluntarily. The essence of this form of support lies in strong emotional bonds characterized by mutuality and maturity. A special role in the structure of informal support at early stages of child development is played by parents-veterans acting as consultants who share their experiences with persons at the beginning of their struggle with a new life situation caused by health problems of their daughter or son. At later stages of child development, especially in adolescence, great importance is attributed to peers' support that can be obtained through the child's relations with both sick and healthy peers. The two forms of support play an important role in fostering competences of the chronically ill child; they complement each other. Persons receiving informal support more effectively search for formal support because they learn where they can get it and how to use it. And the other way around – formal support reinforces informal forms of providing help characterized by mutuality and a lack of hierarchical structure. The atmosphere of egalitarianism and mutual respect lowers the level of fear and depression states, reinforces self-esteem, enhances the development of autonomy and a sense of agency, promotes mutual trust and openness, encourages expressing feelings (Pilecka, 2002).

Becoming a mature and well-functioning person as a developmental success

One of the most significant terms in positive psychology is *well-being* achieved through a *life well-lived*, i.e. active life focused on carrying out tasks and overcoming difficulties resulting from life changes. E. Diener, R.E. Lucas and S. Oishi (2012) define well-being as a cognitive and emotional assessment of our life, including both emotional responses to events and cognitive judgments of satisfaction with life. The assessment refers to six aspects of well-being: self-acceptance, life purpose, personal growth, control over the environment, positive relations with others and autonomy (Ryff, Singer, 2003).

Self-acceptance constitutes the most important dimension of well-being; it is manifested in a positive attitude towards oneself, feeling proud of oneself, accompanied with an awareness of one's strengths and weaknesses, successes and failures.

Another important dimension of well-being is having a life purpose that is defined by specific tasks resulting from undertaken social roles related to age, sex and sociocultural factors, as well as by the chosen hierarchy of values.

An aspect strongly related to having a life purpose is personal growth whose essence lies in the maximal actualization of one's total developmental potentials and special talents enhancing optimal functioning. A unique personal development very often results from battling against adversities and one's psychophysical limitations.

Control over the environment refers to coping with the surrounding reality in such a way that addressing one's needs and accomplishing personal standards is possible. Not only does it consist in controlling what is going on in the closest and further environment but also in engaging in the creation and nurturing of basic microenvironments and their mutual relations in the course of life.

This aspect is explicitly linked with the person's positive social relations being a source of not only pleasure and joy but also deep feelings and social support.

The last mentioned dimension – autonomy – stands for: the ability to manage one's behavior, make choices with one's own and other people's needs in view, and shape social relations based on mutuality

Well-being is presented here as a complex and multidimensional construct and as such has not been a subject of study of pediatric psychology so far, for many years, however, almost all of its aspects, as separate from one another areas of the functioning of children with chronic conditions, have been less or more directly described on the basis of empirical studies. Generalizing the findings of these studies it should be stated that most of the children strive after self-acceptance (Pilecka, 2002). In a situation of proper control over the course of the disease, ill children's self-regulatory competences are even higher than in the case of their healthy peers (Fryt, 2011); pediatric cancer survivors reconstruct their life goals (Zebrack, Chesler, 2002), and sometimes even transcendence expressed through their creative activeness (Pilecka, 2011).

In psychological literature several descriptions of a mature and well-functioning persons can be found. According to C.G. Jung (quoted after: Płużek, 2002), the first researcher to present the thesis that a human develops throughout his or her whole life, the most important traits of full humanness are: bestowing one's love upon oneself and others, realizing one's dignity and worth as well as the dignity of any other person, accepting responsibility for oneself and for others, and taking responsibility for good and evil in oneself and in other people. G. Allport (quoted after: Płużek, 2002), on the other hand, describes a mature person as characterized by such behaviors and attributes as: expanding one's

personality, friendly contact with other people, emotional maturity, realistic attitude to life, talents and self-objectivization: insight and sense of humor, unifying life philosophy. A. Maslow (2006) ascribes many more traits to a mature person, i.e.: realistic perception of reality (a unique ability to discern what is fake, pretended and dishonest in all areas of life), self-acceptance, spontaneity, problem-centering, enduring loneliness with no self-cost and distress, autonomy, freshness of appreciation, peak experiences, sense of community with other people, modesty and respect, strong interpersonal relations, ethics (high moral standards), ability to distinguish between means and goals, sense of humor, creativity, resistance to cultural influences, imperfection, system of values, resolution of dichotomies (desires are in an accord with reason).

The diagram below illustrates the gist of the presented discussion:

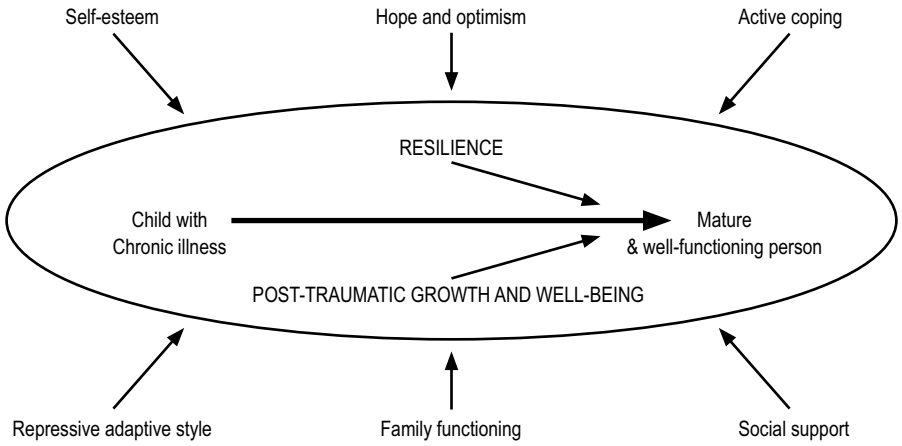

Figure 1. Developmental goal. Becoming a mature and well-functioning person

M. Stachel (2011), when analyzing a life situation of young women with physical disabilities, points out the following criteria that the women have to meet in order to achieve a full personal development: perceiving difficulties and limitations as challenges and tasks, accepting oneself the way one is, opening oneself to the world, a sense of being the subject of one's own life, having a life purpose or several life purposes, expanding the range of values. As the author writes, the process of personal growth requires an enormous effort and will to fight from persons afflicted with disability. Such a person has to come to terms with losing his or her physical fitness, accept oneself as a whole together with all the imperfections and deficits, open oneself to the world, introduce many changes into one's system of values, define one's life purposes and strive after their realization, but above all take control over one's own life that should be ran by disabled persons themselves, even though a presence and help of other persons is often necessary. It is worth noticing here that the system of values

of the person with a somatic disease should also define this person's attitude towards suffering. If the attitude is positive and the person accepts suffering and learns to endure it, some day he or she will find meaning in it that will enhance the person's further work on oneself and his or her personal growth.

Having compared the conceptualization of psychological well-being with a description of a mature and well-functioning person, it can be stated that a human becomes such a person by achieving a full well-being at successive moments and situations of his or her life. In other words, psychological well-being determines the aspiration to become a mature and well- or optimally-functioning person.

The constant process of becoming a mature and well-functioning person – i.e. the person who perceives his or her limitations as tasks or challenges, who stays in communal closeness with others, who accepts oneself and who is aware of one's strengths and weaknesses, who is open to new experiences and to the world, who is the subject of his or her own life, who has got and carries out his or her life goals and expanded system of values – constitutes a fundamental goal of the psychosocial development of children and youth battling against the demands and limitations imposed on them by a chronic somatic disease. In the subject perspective, this process proceeds from an inevitable dependence on others towards a more and more dynamic self-creation. Psychological resilience (e.g. as formulated by E. Grotberg), post-traumatic growth and psychological well-being are regarded as direct determinants of this growth, or in other words – its psychological mechanisms. These determinants, on the other hand, are determined by protective factors of internal (self-esteem, hope and optimism, active coping and repressive adaptive style) and external character (family functioning and social support). It has to be added, though, that this process is possible only if the closest micro-environments of chronically ill children and youth (family, health and educational institutions) promote it through carrying out supportive actions, both informal (creating an emotional and motivating climate) and formal ones (psychoeducational, prophylactic and psychotherapeutic programs), in the context of favorable political solutions for healthcare and education.

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